# John H. Stroger, Jr. Hospital
# ~~2014~~ 2015 Patient Safety Plan

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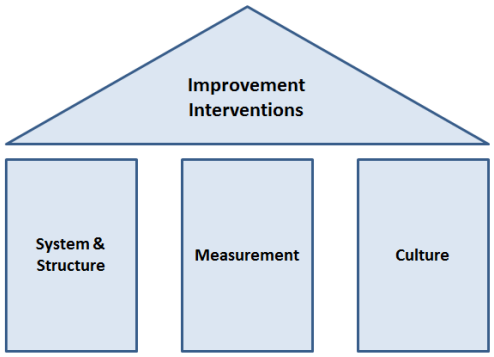
## I. Commitment to Patient Safety

John H. Stroger, Jr. Hospital (Stroger Hospital) is committed to a comprehensive approach to patient safety and quality, including developing a culture of safety that includes an organization-wide commitment to continuous learning.




A comprehensive approach lies at the heart of both evidence-based medicine and modern quality and patient safety approaches. This encompasses a consistent set of expectations, guidelines, tools and training applied by and to everyone associated with the organization from the Board of Directors, medical staff and employees and supports a learning culture leading to a "Just Culture" environment.

> Stroger Hospital uses a learning culture to implement organizational improvement in order to influence Stroger Hospital's ability to create the patient outcomes desired. The Patient Safety Plan places less focus on events, errors and outcomes, and more focus on risk, system design and the management of behavioral choices. With this system, Stroger Hospital strongly encourages an environment of free and open reporting within process systems. This helps to build a culture which encourages coaching and honesty at all levels, in order to bring about the best possible outcomes.

The development and implementation of a comprehensive plan of improvement further demonstrates evidence of the commitment to quality and patient safety. This Patient Safety Plan seeks to systematically raise the level of organizational performance through the collaboration of the Board of Directors, leadership, medical staff and ultimately all employees of the hospital.

The Board of Directors will commit the appropriate human and financial resources to assure the integrity and sustainability of the patient safety program.

The purpose of the patient safety plan is to create a foundation, aligned with the Quality Assessment and Performance Improvement Plan (Quality Plan), for improving patient safety through:

1. A standardized method to categorizing events and also classifying events based on level of harm,
2. The implementation of advanced measurement tools for identifying adverse events,
3. Proactive approaches to reduce harm and adverse events, and
4. A governance structure that elevates communication throughout the organization and ensures accountability for the established patient safety priorities.

## II. Foundation for the Patient Safety Plan

The Patient Safety Plan and all related activities are conducted in a manner consistent with Stroger Hospital's mission.

> *John H. Stroger, Jr. Hospital of CCHHS' mission is to deliver integrated health services with dignity and respect regardless of a patient's ability to pay; to foster partnerships with other health providers and communities to enhance the health of the public; and to advocate for policies which promote and protect the physical, mental and social well-being of the people of Cook County.*

The Patient Safety Plan provides guidance to the overall safe practices at Stroger Hospital by aligning with the Institute for Healthcare Improvement (IHI), the National Quality Forum, the Centers for Medicare and Medicaid Services, the Joint Commission, the Agency for Healthcare Quality (AHRQ), and the American Society for Quality (ASQ), placing the patient at the center and incorporating evidence-based practice guidelines to the delivery of care. Together with the Quality Plan, Stroger Hospital has established an organization-wide, integrated patient safety program within its performance improvement activities.

## III. Definitions

The National Patient Safety Foundation (NPSF) has defined the characteristics of **patient safety** as "the avoidance, prevention, and amelioration of adverse outcomes or injuries stemming from the processes of health care itself."

~~The Agency for Healthcare Research Quality (AHRQ) defines **patient safety** as "a discipline in the health care sector that applies safety science methods toward the goal of achieving a trustworthy system of health care delivery. Patient safety is also an attribute of health care systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events."~~

**Patient Safety**, as defined by the World Health Organization, is the prevention of errors and adverse effects to patients that are associated with health care.

**Patient safety event** is an event, incident, or condition that could have resulted or did result in harm to a patient.

The definition used for **harm** is aligned with the Institute for Healthcare Improvement (IHI) and is as follows: unintended physical injury resulting from or contributed to by medical care that requires additional monitoring, treatment or hospitalization, or that result in death.

An **error** is commonly defined as an act of commission (doing something wrong) or omission (failing to do the right thing) leading to an undesirable outcome or significant potential for such an outcome.

A **good catch or near miss** is an unplanned event that did not result in injury, illness or damage – but had the potential to do so.

~~An **adverse event** is defined as events which are unintended consequences of medical care, whether preventable or not.~~

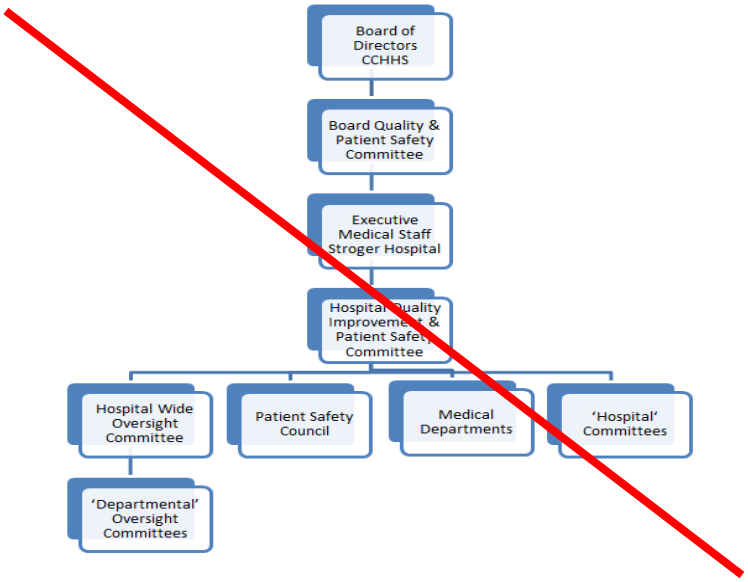
An **adverse event** is defined as a patient safety event that resulted in harm to a patient.

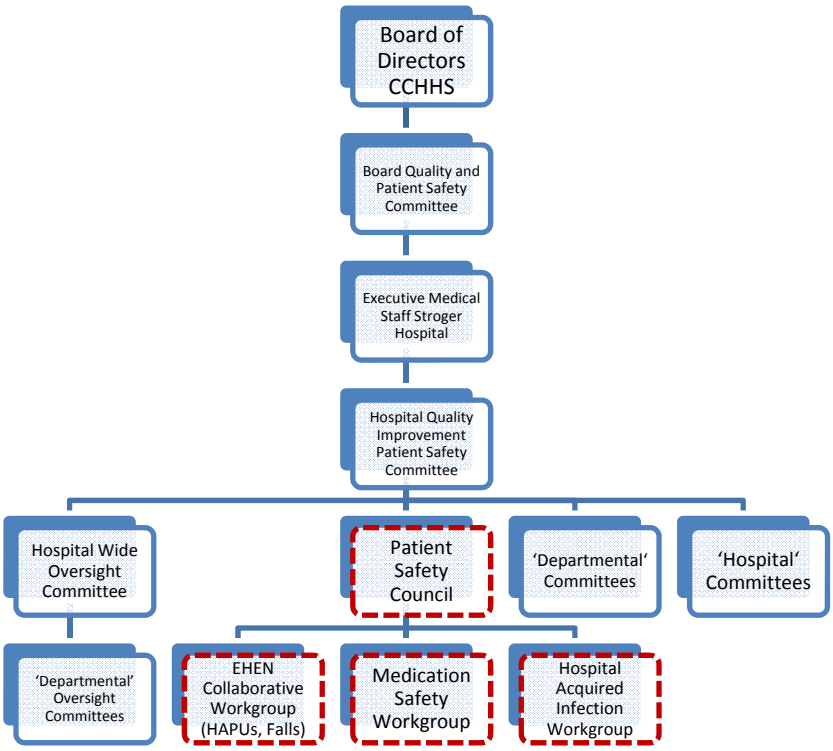
The Joint Commission defines a **sentinel event** as an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response.

A **Root Cause Analysis (RCA)** is a systematic investigation technique that uses information gathered during an intense assessment of an undesirable event to determine the underlying reasons for the deficiencies or failures.

## IV. Roles and Responsibility

The Patient Safety Plan supports the organizational structure established by the CCHHS Board of Directors.




**Communication between all the elements of the structure is essential for the successful implementation of this plan and is further outlined in the Quality Plan.**

**The CCHHS Board of Directors:**

- Is accountable and ultimately responsible for holding senior management, leaders and managers accountable for the quality improvement goals and ensuring that they are integrated with the organization's strategic initiatives;
- Ensures that the necessary appropriate human and financial resources and processes are in place to keep patients safe;
- Ensures all patients will be provided with the highest-quality care possible while incorporating the foundations of the Quality Plan;
- Reviews summaries of improvement activities and performance indicators to track results of overall performance; and
- Establishes committees and subcommittees as necessary to fulfill their role of the overseer of patient safety *(The Hospital Quality Improvement & Patient Safety Committee shall provide oversight and direction for implementation of the Patient Safety Plan.)*.

**The Board Quality & Patient Safety Committee:**

- Oversees the quality and patient safety activities within the organization;
- Ensures that the organization takes a proactive approach to planning for patient safety;
- Ensures that an integrated safety program exists within the organization;
- Establishes priorities for performance improvement to the medical staff and quality committees;
- Oversee reports to the Board of Directors regarding the effectiveness of the Hospital Quality Improvement & Patient Safety Committee and recommended revisions to the Committees.

**The Executive Medical Staff Stroger Hospital:**

- Oversees the quality and patient safety activities within the organization;
- Ensures that the organization takes a proactive approach to planning for patient safety;
- Ensures that an integrated safety program exists within the organization;
- Approves the minutes and activities of the Hospital Quality Improvement and Patient Safety Committee prior to presentation to the Board of Directors;
- Establishes priorities for performance improvement; and
- Champions and extends concepts embodied in CCHHS' mission and related areas of learning and process improvement throughout the medical staff.

**The Hospital Quality Improvement & Patient Safety Committee (Quality Committee):**

- Serves the dual function of oversight of the Quality Program as well as the Patient Safety Program;
- Reviews all quality metrics, departmental and committee quality data, and prioritizes performance improvement projects;
- Reports the activities of the committee to the Executive Medical Staff;
- Provides leadership for measuring, assessing and improving systems and processes;
- Establishes priorities for performance improvement and monitors progress toward the achievement of the plans; and
- Champions and extends concepts embodied in CCHHS' mission and related areas of learning and process improvement throughout the organization.

**The Hospital Wide Oversight Committee:**

- Evaluates significant events in collaboration with 'Departmental Oversight Committees';
- Presents results of investigations and recommendations for performance improvement to the Quality Committee;
- Reports all significant events and results of the evaluation of such events to the Executive Medical Staff;
- Provides direction to the organization on patient safety matters;

- Provides guidance and support for hospital-wide patient safety efforts;
- Promotes a culture of safety through the coordination and implementation of patient safety programs; and
- Approves initiatives and activities to improve patient safety throughout the hospital.

**The Patient Safety Council:**

- Will be established as a multidisciplinary committee that is responsible for coordinating and implementing patient safety programs and initiatives, including directing and overseeing proactive risk reduction and patient safety;
- Evaluates trends from patient safety reports, adverse event analysis and other sources;
- Oversees mandatory reporting of safety events to external organizations and regulators;
- Prioritizes and recommends actions to improve patient safety throughout the hospital to the Quality Committee;
- Recognizes and celebrates successful improvement efforts related to patient safety; and
- Recommends revisions and development of policies and procedures related to patient safety to the Quality Committee.

**The Department of Quality and Patient Safety:**

- Is responsible for the implementation of the Patient Safety Plan led by the Chief Quality Officer and executed in collaboration with the Hospital Wide Oversight and Quality Committees, departmental quality committees, hospital and system leadership and the System Departments of Risk Management, Legal, and Compliance;
- Ensures alignment among the Quality Assessment and Performance Improvement Plan and the Patient Safety Plan;
- In collaboration with the Department of Risk Management, is accountable to establishing the workflow in reviewing, managing, and closing reports within the voluntary event reporting system;
- Provides education and training to staff, leadership and physicians regarding new safety practices, measuring safety outcomes, and developing programs to improve them;
- Supervises the approach to serious events and to preventing future errors;
- Collaborates with members of the leadership team to create and implement performance improvement plans;
- Leads and coordinates Performance Improvement (PI) projects hospital-wide and educates PI concepts;
- Provides recommended methodologies to capture, analyze and report data throughout the organization;
- Ensures data are targeted to improve safety, efficiency and quality of patient care;
- Analyzes data for trends and provides consultative assistance with data analysis to foster a widespread understanding of processes to drive performance improvement; and
- Leads on-going education and training to staff at all levels, including Medical Staff, to improve compliance, quality and patient safety throughout the organization.

## V. Objectives and Goals of the Patient Safety Plan

To facilitate the achievement of the mission and strategic goals, as well as promote safe practices, the Patient Safety Plan is specifically designed to encompass the following objectives:

A. **Create systems** that anticipate errors and either prevent or catch them before they cause harm;
B. **Establish structures** for reporting and a process for managing reports in the event reporting system;
C. **Develop a culture of safety** where providers feel safe and supported when they report medical errors or near misses and voice concerns about patient safety; and
D. **Establish safety priorities and targets**; and
E. **Charter safety programs** through teams, workgroups or projects.

**The Patient Safety plan addresses the following key components and its applicable goals:**

| OBJECTIVE: | GOAL: | Q3 2014 | Q4 2014 | Q1 2015 |
|---|---|---|---|---|
| | | ACTION PLAN: | | |
| **1. Create Systems** that anticipate errors & either prevent or catch them before they cause harm. | a. Enhance retrospective chart review process.<br>b. Establish an automated surveillance process.<br>c. Conduct a proactive risk assessment in a high risk area. | | Complete an in-depth analysis of risk point utilizing the methods of FMEA. | Implement Trigger Tools.<br>Develop automated surveillance reports in Cerner. |
| **2. Establish Structures** for reporting and a process for managing reports in the event reporting system. | a. Implement new electronic Voluntary Reporting System & participate in Patient Safety Organization.<br>b. Develop a structure to educate employees system-wide of the process for reporting hazards, errors and adverse events.<br>c. Establish a process for providing feedback regarding reported events. | Implemented e-MERS & PSO with UHC.<br>Create process for reviewing & closing reports in e-MERS. | Increase number of events reported by 10%.<br>Create process for communicating outcome of reported events. | |
| **3. Develop a Culture of Safety** where providers feel safe and supported when they report medical errors or near misses & voice concerns about patient safety. | a. Provide education on patient safety plan that emphasizes importance of blending a systems focus with appropriate individual accountability.<br>b. Establish a recognition program that rewards safe practices.<br>c. Improve overall perceptions of safety as measured by the Culture of Safety Survey. | | Educate Medical staff, Hospital Wide Oversight & the Quality Committees on the objectives and goals of the patient safety plan.<br>Include patient safety presentation in monthly New Employee Orientation.<br>Develop 'Great Catch' awards program. | Re-evaluate culture of safety and develop action plan. |
| **4. Establish Safety Priorities & Targets.** | a. Develop Patient Safety Dashboard that includes national measures and benchmarks.<br>b. Facilitate the development of action plans associated with measures not meeting benchmarks.<br>c. Assess and improve processes related to hand-off, transition and communication | Complete 2014 Leapfrog Safety Survey.<br>Develop method to track & report departmental progress and compliance of RCA action plans. | Present Patient Safety Dashboard monthly to Hospital Wide Oversight Committee.<br>Establish & implement a plan to improve performance of each leap. | |
| **5. Charter Safety Programs** through teams, workgroups or projects. | a. Coordinate Improvement Efforts in order to ensure that capital, people, facilities & technologies are matched to strategic priorities for safe practices.<br>b. Reduce and eliminate variation in care. | Establish workgroups focused on medication safety, reducing patient falls & hospital acquired pressure ulcers.<br>Revise or develop policies, procedures and protocols. | Establish Patient Safety Council. | |

| OBJECTIVE: | GOAL: | 2014 | Q1 - Q2 2015 | Q3 – Q4 2015 |
|---|---|---|---|---|
| | | ACTION PLAN: | | |
| **1. Create Systems** that anticipate errors & either prevent or catch them before they cause harm. | a. Enhance retrospective chart review process.<br>b. Establish an automated surveillance process.<br>c. Conduct a proactive risk assessment in a high risk area. | • Completed an in-depth analysis of risk point utilizing the methods of FMEA. | • Implement Trigger Tools.<br>• Develop automated surveillance reports in Cerner.<br>• Develop proactive plan to improve the accuracy of patient identification (NPSG.01.01.01) and improve the safety of clinical alarm systems (NPSG.06.01.01). | |
| **2. Establish Structures** for reporting and a process for managing reports in the event reporting system. | a. Implement new electronic Voluntary Reporting System & participate in Patient Safety Organization.<br>b. Develop a structure to educate employees system-wide of the process for reporting hazards, errors and adverse events.<br>c. Establish a process for providing feedback regarding reported events. | • Implemented eMERS & PSO with UHC.<br>• Created process for reviewing & closing reports in eMERS.<br>• Created process for communicating outcome of reported eMERS events. | • Increase number of events reported by 10%.<br>• Create process for communicating root cause analysis findings and action plans. | |
| **3. Develop a Culture of Safety** where providers feel safe and supported when they report medical errors or near misses & voice concerns about patient safety. | a. Provide education on patient safety plan that emphasizes importance of blending a systems focus with appropriate individual accountability.<br>b. Establish a recognition program that rewards safe practices.<br>c. Improve overall perceptions of safety as measured by the Culture of Safety Survey. | • Educate Medical Staff, Hospital Wide Oversight & the Quality Committees on the objectives and goals of the patient safety plan.<br>• Develop 'Great Catch' awards program. | | • Include patient safety presentation in monthly New Employee orientation.<br>• Re-evaluate culture of safety and develop action plan.<br>• Implement Safety Briefings to encourage and reward reporting of safety problems and concerns, increase awareness of patient safety issues, and create an environment in which safety issues are shared and integrated into daily work. |
| **4. Establish Safety Priorities & Targets**. | a. Develop Patient Safety Dashboard that includes national measures and benchmarks.<br>b. Facilitate the development of action plans associated with measures not meeting benchmarks.<br>c. Assess and improve processes related to hand-off, transition and communication | • Completed 2014 Leapfrog Safety Survey.<br>• Developed method to track & report departmental progress and compliance of RCA action plans. | • Present Patient Safety Dashboard monthly to Hospital Wide Oversight Committee and quarterly to Hospital Quality Improvement and Patient Safety Committee.<br>• Establish & implement a plan to improve performance of each leap within the Leapfrog Safety Survey. | |
| **5. Charter Safety Programs** through teams, workgroups or projects. | a. Coordinate Improvement Efforts in order to ensure that capital, people, facilities & technologies are matched to strategic priorities for safe practices.<br>b. Reduce and eliminate variation in care. | • Established Patient Safety Council.<br>• Established workgroup to reduce patient falls & hospital-acquired pressure ulcers. | • Establish workgroups focused on medication safety and hospital-acquired infections.<br>• Revise or develop policies, procedures and protocols focused on behavioral management (e.g. AMA/elopements, restraints, chain of custody) and radiation safety. | |

**The patient safety initiatives for 2015 will focus on 8 areas and will be prioritized based on the following criteria:**

- *Strategic Alignment* - to organizational goals and regulatory requirements;
- *Visibility and Cultural Impact* – demonstrating an opportunity to show commitment in safety improvement and create a safety culture;
- *Value* – to simultaneously improve safety and cut costs or increase revenue;
- *Feasibility* – easy to implement;
- *Probability* – to contributing to another event; and
- *Severity of Risks* – having the most severe potential consequences.

| Prioritization Matrix | Origin of Safety Priority | | | |
|---|---|---|---|---|
| | Organizational Priority | TJC NPSG | CMS | EHEN |
| **Alarm Management** | | x | | |
| **Behavioral Management** (e.g. chain of custody, AMA/elopement, restraints) | x | | x | |
| **Culture of Safety** | x | x | | x |
| **Hospital-Acquired Conditions** (i.e. Falls with Injury, HAPUs) | | | x | x |
| **Hospital-Acquired Infections** | | | x | x |
| **Medication Safety** | | x | | x |
| **Patient Identification** | | x | | |
| **Radiation Safety** | x | | | |

| *LEGEND* |
|---|
| TJC: The Joint Commission<br>NPSG: National Patient Safety Goal<br>CMS: Centers for Medicare & Medicaid Services<br>EHEN: Essential Hospitals Engagement Network |

Staines, A. (2015). Prioritize: How does an organization manage a portfolio of projects. Institute for Healthcare Improvement's 26th Annual National Forum on Quality Improvement in Health Care.

## VI. Assessment of Patient Safety

Data helps organizations make the right decisions, particularly when patterns and trends are observed. Data is necessary to evaluate the hospital-wide safety program through an analysis of potential system failures and reported adverse events and near misses. Safety and harm at an institution may be measured along three domains: structure, process and outcomes. Structural measures describe systems in place at the institution which support safety, as well as specific aspects of staffing and training. Process measures are those systems of care most likely to impact patient safety, and the outcomes represent the actual impact on patients.

An assessment of the most recent data (Quarter 2 2014) included the following results from the culture of safety survey, summary data from the Leapfrog Safety Survey, data from the voluntary event reporting system and harm measures embedded in the claims data bases as reported to CMS (Centers for Medicare and Medicaid Services). The performance measures are summarized in the table below.

| PERFORMANCE MEASURES | DOMAIN[¥] | DATA SOURCE | MEASURE ORIGIN |
|---|---|---|---|
| **John H. Stroger, Jr. Hospital** | | | |
| Leadership Expectations & Actions Promoting Safety | S | Culture of Safety Survey | AHRQ* |
| Leadership Support for Patient Safety | S | | |
| Staffing | S | | |
| Handoffs & Transitions | S | | |
| Teamwork within Units | S | | |
| Teamwork across units | S | | |
| Non-punitive Response to Error | S | | |
| Feedback & Communication about Error | S | | |
| Culture of Safety Leadership Structures & Systems | S | Leapfrog Safety Survey | NQF* |
| Culture Measurement, Feedback, & Intervention | S | | |
| Teamwork Training & Skill Building | S | | |
| Identification and Mitigation of Risks & Hazards | S | | |
| Nursing Workforce | S | | |
| Medication Reconciliation | S | | |
| Hand Hygiene | S | | |
| Care of the Ventilated Patient | S | | |
| CPOE | S | | |
| ICU Physician Staffing | S | | |
| ***National Patient Safety Goals*** | | | |
| Identify Patients Correctly *(# of Identified Errors/# Observations)* | P | Cerner, Meaningful Use | TJC* |
| Medication Reconciliation | P | | |
| Use Alarms Safely *(# of Alarms Not Responded to/# of Simulations)* | P | | |
| Handwashing Compliance (average) | P | | |
| Compliance BEFORE Patient/Env Contact | | | |
| Compliance AFTER Patient/Env Contact | | | |
| ***Hospital Acquired Conditions (HACs)*** | | | |
| Foreign Object Retained | O | Cerner, Administrative Reports | CMS* |
| Air Embolism | O | | |
| Pressure Ulcer (Stage 3 and 4) | O | | |
| Falls and Trauma | O | | |
| ***Hospital Acquired Infections (HAIs)*** | | | |
| CLABSI | O | Cerner, Administrative Reports | CMS, CDC, NHSN* |
| CAUTI | O | | |
| SSI | O | | |
| VAP | O | | |
| ***Patient Safety Indicators (PSIs): VBP Measure*** | | | |
| ***AHRQ PSI-90 Patient Safety for Selected Indicators (Composite)*** ^ | O | CMS | AHRQ* |
| PSI 4: Death Among Surgical Inpatients | O | Cerner, Administrative Reports | |
| PSI 6: Iagrogenic Pneumothorax | O | | |
| PSI 11: Postoperative Respiratory Failure | O | | |
| PSI 12: Postopertaive PE/DVT | O | | |
| PSI 14: Postopertiave Wound Dehiscence | O | | |
| PSI 15: Accidental Puncture or Laceration | O | | |
| ***Other*** | | | |
| Overall Perceptions of Safety | O | Culture of Safety Survey | AHRQ |
| Mortality Report | O | Internal | CMS |
| Readmission Report | O | Internal | CMS |

[¥] Domain: S = Structure, P = Process, O = Outcome

[*] AHRQ: Agency for Healthcare Research & Quality
NQF: National Quality Forum
TJC: The Joint Commission
CMS: Centers for Medicare & Medicaid Services
CDC, NHSN: Centers for Disease Control, National Healthcare Safety

# Patient Safety Dashboard

| PERFORMANCE MEASURES | IOM* Improvement Aim | DOMAIN¥ | Target | DATA SOURCE | MEASURE STEWARD |
|---|---|---|---|---|---|
| **John H. Stroger, Jr. Hospital** | | | | | |
| ***Hospital Acquired Conditions (HACs)*** | | | | | |
| **Pressure Ulcer Stages III & IV** | Safe | O | TBD | Cerner, Administrative Reports | AHRQ* |
| **Falls with Injury (per 1,000 patient days)** **Note:** As of July 1, 2014, number of Falls includes Med-Surg and ICU/CCU Units only. Prior data included all patient falls. | | O | 0.8 | | The Joint Commission* |
| ***Hospital Acquired Infections (HAIs)*** | | | | | |
| **Central Line Blood Stream Infections (CLABSI) Standardized Infection Ratio (SIR)** | Safe | O | SIR = 0.32 | Cerner, Administrative Reports | CMS, CDC, NHSN* |
| **Catheter Associated Urinary Tract Infection (CAUTI) SIR** | | O | SIR = 0.77 | | |
| **Surgical Site Infections (SSI) SIR** | | O | SIR = 0.51 | | |
| **Ventilator Associated Events (VAE)/Ventilator Associated Pneumonia (VAP) Rate** | | O | TBD | | |
| ***Medication Safety*** | | | | | |
| ***Number of Medication Errors*** | Safe | O | TBD | eMERS | Institute for Healthcare Improvement* |
| **Medication Events with Injury per 100 Admissions** | | O | | eMERS | |
| ***Reported Events*** | | | | | |
| ***Serious Reportable Events (days since)*** | Safe | O | TBD | eMERS | Institute for Healthcare Improvement |
| ***Adverse events per 100 admissions*** | | O | | | |
| **# of Serious Reportable Events** | | O | | | |
| SURGICAL OR INVASIVE PROCEDURE EVENTS (1A - 1E) | | O | | | |
| PRODUCT OR DEVICE EVENTS (2A - 2C) | | O | | | |
| PATIENT PROTECTION EVENTS (3A - 3C) | | O | | | |
| CARE MANAGEMENT EVENTS (4A - 4I) | | O | | | |
| EVIRONMENTAL EVENTS (5A - 5D) | | O | | | |
| RADIOLOGIC EVENTS (6A) | | O | | | |
| POTENTIAL CRIMINAL EVENTS (7A - 7D) | | O | | | |
| **# of Patients Affected** | | O | | | |
| **# of Root Cause Analyses Conducted** | | O | | | |
| **# of Events that are assocated with NPSG*** | | O | | | |
| ***Harm events (≥ Harm Score of 6 or Category E)*** | | | | | |
| **Category E: Error that may have contributed to or resulted in temporary harm to patient & required intervention** | Safe | O | TBD | eMERS | National Coordinating Council for MERP* |
| **Category F: Error that may have contributed to or resulted in temporary harm to patient & required initial or prolonged hospitalization** | | O | | | |
| **Category G: Error that may have contributed to or resulted in permanent patient harm** | | O | | | |
| **Category H: Error that required intervention necessary to sustain life** | | O | | | |
| **Category I: Error occurred that contributed to or resulted in the patient's death** | | O | | | |
| ***Litigation Statistics*** | | | | | |
| **# of cases in litigation (by date of care)** | Not Applicable | O | Not Applicable | Internal | Internal |
| **Open Cases** | | | | | |
| **Closed Cases** | | | | | |
| **Award Amounts** | | O | | | |

***Note:*** Serious Reportable Events (SREs) are also known as sentinel events and are defined by the National Quality Forum (http://www.qualityforum.org/Topics/SREs/List_of_SREs.aspx).

***LEGEND***

¥ Domain: S = Structure, P = Process, O = Outcome

* IOM: Institute of Medicine
AHRQ: Agency for Healthcare Research & Quality
NQF: National Quality Forum
TJC: The Joint Commission
CMS: Centers for Medicare & Medicaid Services
CDC: Centers for Disease Control
NHSN: National Healthcare Safety Network
IHI: Institute for Healthcare Improvement
MERP: Medication Error Reporting and Prevention

IOM Improvement Aims:
Safe, Effective, Patient-Centered, Timely, Efficient and Equitable

## VII. Specific Outcome Measures

A. One of the greatest challenges in measuring and improving patient safety is the correct identification of patient safety events. The following table highlights some of the advantages and disadvantages of the most common methods of measuring errors and safety advents. The scope of the Patient Safety program includes the full range of safety issues, from near misses to sentinel events *also classified by NQF and CMS as serious reportable events.

| Measurement Strategies | Advantages | Disadvantages |
|---|---|---|
| Retrospective Chart Review | Considered the "gold standard" due to ability to obtain rich detailed clinical information. | Costly, labor-intensive, and consists only of a retrospective review. |
| Voluntary Event Reporting System | Useful for internal quality improvement and case-finding, highlights adverse events of which providers' perceive as important. | Capture small fraction of adverse events, retrospective review only based on provider self-reports, no standardization or uniformity of adverse events reported. |
| Automated Surveillance and Trigger Tools | Can be used retrospectively or prospectively to help screen patients who may be at high risk for adverse events using standardized protocols. | Need electronic data to run automated surveillance, high proportion of "triggered" cases can be false positives. |
| Administrative/Claims Data | Low-cost, readily available data, useful for tracking events over time across large populations, can identify "potential" adverse events. | Delayed results, concerns over variability and inaccuracy of ICD-9-CM codes across and within systems, may detect high proportion of false positives thereby requiring additional chart review. |

B. This table provides additional performance indicators for measuring, analyzing and improving patient safety. Several studies have reported the increased use by hospitals of trigger tools to detect adverse events through the screening of medical records for certain triggers which may suggest that an adverse event has occurred. As a well-developed, well-documented, and publicly available approach to detect adverse events in hospital patients, the trigger tool measures can advance patient safety by identifying trends and areas of potential concern. These measures will be evaluated and reported to the Hospital Wide Oversight Committee as noted within the action plan of the Objectives and Goals section.

| Trigger Tool Measures | DOMAIN[¥] | DATA SOURCE | MEASURE ORIGIN |
|---|---|---|---|
| ***Adverse events per 1,000 patient days*** | O | Cerner, Administrative Data | NA |
| ***Adverse events per 100 admissions*** | O | | |
| ***Percent of admissions with an adverse event*** | O | | |
| ***Care Module Triggers*** | O | | |
| **Any code or arrest** | O | | |
| **Mortality** | O | | |
| **Readmission within 30 days** | O | | |
| ***Medication Module Triggers*** | O | | |
| **PTT >100 s** | O | | |
| **INR >6** | O | | |
| **Vitamin K administration** | O | | |
| **Narcan (Naloxone) use** | O | | |
| ***Surgical Module Triggers*** | O | | |
| **Return to surgery** | O | | |
| **Intubation/reintubation in postanesthesia care unit** | O | | |
| **Intra- or postoperative death** | O | | |
| ***Intensive Care Module Triggers*** | O | | |
| **Readmission to intensive care** | O | | |
| **Intubation/reintubation** | O | | |

[¥] Domain: S = Structure, P = Process, O = Outcome

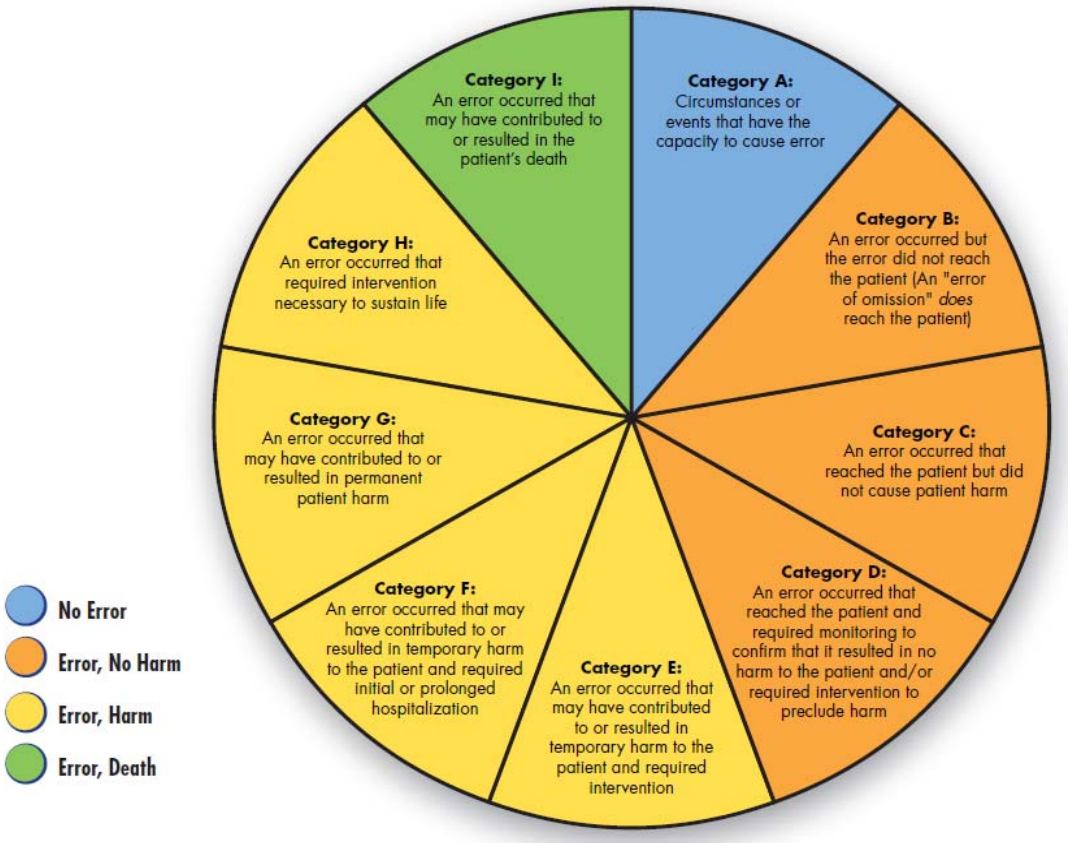
C. A standardized approach to categorizing events in the Voluntary Event Reporting System, for performance improvement purposes, will include the identification of the following type, category and contributory factors (as applicable). Events are referred to the most appropriate manager for evaluation and remediation:

| Type |
|---|
| Medication |
| Surgical |
| Diagnostic |
| Human Factors |
| Transition and Handoff |
| Healthcare-Associated Infection |

| Category | Contributory Factors |
|---|---|
| Organization and Management | • Financial resources and constraints<br>• Policy standards and goals<br>• Safety culture and priorities |
| Work Environment | • Staffing levels and mix of skills<br>• Patterns in workload and shifts<br>• Design, availability, and maintenance of equipment<br>• Administrative and managerial support |
| Teamwork and Communication | • Verbal communication<br>• Written communication<br>• Supervision and willingness to seek help<br>• Team leadership |
| Individual staff member | • Knowledge and skills<br>• Motivation and attitude<br>• Physical and mental health |
| Task | • Availability and use of protocols<br>• Availability and accuracy of test results |
| Patient | • Complexity and seriousness of condition<br>• Language and communication<br>• Personality and social factors |

Reference: Wachter, R.M. 2012. Understanding Patient Safety. The McGraw-Hill Companies, Inc.

D. Aligned with the National Coordinating Council for Medication Error Reporting and Prevention, each event is classified by the level of harm to the patient. The type of event (from C, above) and the level of harm (below) together constitute an event taxonomy which will be used to track event rates over time.

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E. All events submitted into the electronic medical event reporting system (e-MERS) are to comply with the Adverse Events and Incident Reporting Policy.
   a. Employees are encouraged to report all events, whether a near miss, adverse event and/or sentinel event.
   b. Review, follow up and closing of reports is to occur within 30 calendar days (Appendix A).
   c. Sentinel events may be reported verbally to the Risk Management or to the Executive Medical Director.

F. Additional sources of information about opportunities for improving patient safety and quality of care include but are not limited to:
   a) The Risk Management Program, including pending litigation,
   b) Failure Mode and Effects Analyses (FMEA),
   c) The Safe Medical Device Reporting Program,
   d) Administrative databases (e.g. Metropolitan Chicago Health Care Council, Illinois Hospital Association, American Hospital Association, Comp Data, National Practitioners Database, IDPR, Cook County Perinatal Network),
   e) Patient Relations Reports, and
   f) Regulatory and Accreditation Surveys (e.g. IDPH, CMS, The Joint Commission).

## VIII. <u>Evaluation of Events</u>

A. Respectful management of clinical adverse events is evidenced by the following elements to those most directly affected, which includes patients as well as employees (as they can be victims too):
   a) Empathy,
   b) Disclosure,
   c) Support,
   d) Assessment,
   e) Resolution,
   f) Learning, and
   g) Improvement.

B. All events, whether determined to be a sentinel event or adverse event, that are directed by the Executive Medical Director for further investigation via a root cause analysis will be analyzed as follows:
   a. Preliminary investigation includes a review of the Event Form for RCA Consideration (Appendix B) and the voluntary event reporting system (if applicable).
   b. RCA Process ideally includes Three Meetings:
      1. *Meeting 1* initiates with a review of the RCA Ground Rules and Guidelines (Appendix C) and includes discussion of sequence of events, identification of actions taken at or near the time of the event, and suggestions of causes and solutions with all team members associated with the event using the RCA Meeting Form (Appendix D). Prior to Meeting 2, a drill down of the event with select team members is conducted to better understand "why" and "how" the event occurred via the RCA Contributory Factor Tree diagram (Appendix E).
         a. Code each 'cause' with "insufficient data," "non-contributory," or "contributory".
         b. Assign team members to obtain any missing data.
      2. *Meeting 2* includes a review of the RCA Contributory Factor Tree associated with the event. Generate at least one corrective action or improvement for each "contributory" factor.
         a. Check for omissions, better organization and more logical flow.
         b. Prior to Meeting 3, complete the RCA Analysis and Action Plan Framework (Appendix F).
      3. *Meeting 3* includes a review of the event sequence, the RCA Contributory Factor Tree diagram, and the RCA Analysis and Action Plan. The meeting should include, at minimum,

Leadership of the involved departments, all involved personnel, Risk Management, and the Quality Department. Specific tasks and timelines are assigned at this meeting.

C. Aligned with the Quality Plan and The Joint Commission's RCA framework and the Sentinel Events Policy, immediate investigation of sentinel events should begin within 48 hours and Meeting 1 of the RCA is to be scheduled in 7 days. A 30-day time period from the event, or from becoming aware of the event, to complete an acceptable root cause analysis (Appendix G) is required.

D. As an in-depth internal investigation, a root cause analysis, will be considered acceptable if it has the following characteristics:
   a) Applies all elements of the RCA Process: Ground Rules and Guidelines document,
   b) Includes participation by the Leadership of the organization and by the individuals most closely involved in the processes and systems under review,
   c) Considers any relevant literature, and
   d) Includes documentation and reporting of patient safety improvement activities by the accountable Department Leader at the Hospital Wide Oversight Committee meeting(s) until the Committee determines the corrective actions are closed.

E. Documentation and Reporting of Patient Safety Improvement Activities:
   a. Reports reflecting performance results or progress on patient safety projects and initiatives will utilize common templates for reporting. These templates are used in the spirit of creating user-friendly reports that reflect a systematic approach to improvement. Such templates include but are not limited to:
      i. Performance dashboards;
      ii. Analysis and action plans;
      iii. Control charts for monitoring and evaluation (i.e. tracking and trending); and
      iv. Ongoing professional practice evaluation.
   b. Documentation of improvement activities supports both a disciplined, comprehensive approach to improvement and accountable reporting. The focus of the documentation is to share learning and to support replication and safe practices.
   c. Documentation will be maintained in accordance with the organization's policy on confidentiality of quality improvement information.

F. Relevant findings from proactive risk assessments and root cause analyses, including effectiveness and safety of services provided, may be considered for:

   c. Reappraisal/reappointment of medical staff members;
   d. The renewal or revision of the clinical privileges of mid-level practitioners who practice independently or under supervision of physicians; and
   e. Performance appraisals of employees.
   f. Provider peer review process and/or OPPE/FPPE as described in the Medical Staff Bylaws.

## IX. Communication and Education

A. Hospital staff members receive information regarding the hospital's mission, vision, values and quality activities through hospital and departmental orientation, staff meetings, and other forms of communication as appropriate.
B. The Department of Quality and Patient Safety coordinates patient safety and quality improvement activities.
C. The Department of Quality and Patient Safety works to improve communication and collaboration around patient safety efforts by identifying opportunities for collaboration between committees and working to minimize and eliminate variation in care. The Department of Quality and Patient Safety acts as an in-house consultant to leadership, staff, and Medical Staff. It also provides direct support and logistical coordination for regulatory compliance activities.

D. The Department of Quality and Patient Safety arranges with each department to provide the department with action plans and risk mitigation strategies which are generated from events reported by members of the department.
E. The President of the Medical Staff, or designee, coordinates reporting in regards to practitioner-specific findings of the peer review, credentialing and OPPE/FPPE process. The Medical Staff Office works to communicate patient safety initiatives to the medical staff at large.

## X. Recognition

A. A "Good Catch" Program will be established to encourage the identification of potential system errors or problems before they reach the patient and/or cause harm.
    a. Goals of the program will be to:
        i. Strengthen the culture of safety.
        ii. Allow staff to be recognized for their contributions.
        iii. Create a learning culture through a non-punitive environment.
    b. A "good catch" is recognition of an event or circumstance which had the potential to cause an incident or critical incident but which did not occur due to corrective action and/or other timely intervention following recognition. A near miss may be submitted as a "good catch".
    c. All "good catches" will be reviewed by the Patient Safety Council based on the following criteria:
        i. Impact on patient safety.
        ii. Impact on quality of patient care.
        iii. Impact on service (timeliness, efficiency, effectiveness).
        iv. Opportunity to spread and increase positive impact across the organization.
    d. The program will recognize employees, at minimum, on a quarterly basis.
B. Additional recognition programs are under discussion and may be instituted in alignment with the Quality Plan and Patient Safety Plan.

## XI. Approval of Plan

The Board of Directors approves the Patient Safety Plan after review and approval by the Board's Quality and Patient Safety Committee and the Hospital Medical Staff's Executive Medical Staff Committee.

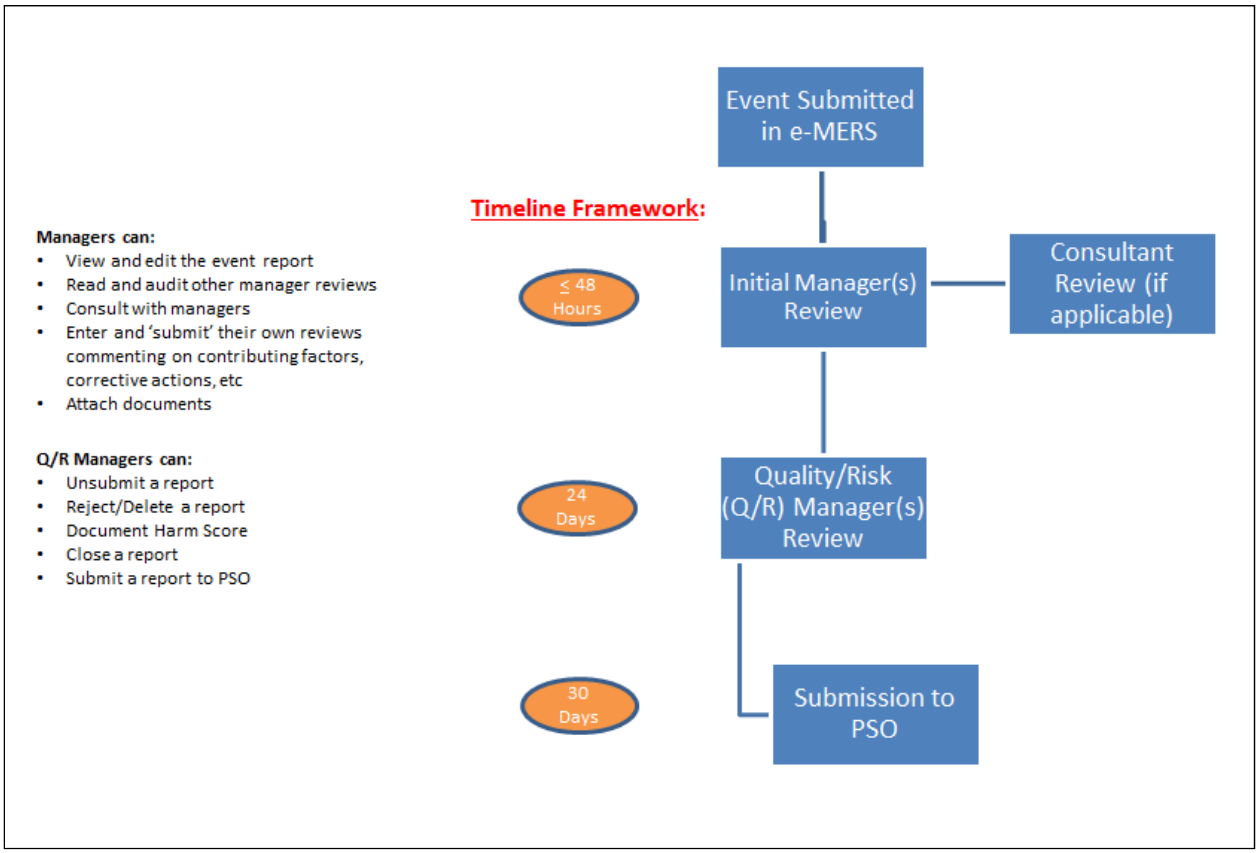
## XII. Confidentiality

All information and data generated relating to the activities delineated in the Patient Safety Plan are used to evaluate and improve performance and the quality of patient care and services. The confidential nature of the information will be respected according to the guidelines and parameters established by the federal Health Quality Improvement Act and State of Illinois Medical Studies Act. The confidentiality of patient specific data will be protected in observance of HIPAA regulations and aggregated, de-identified data will be used for quality data reporting.

Every individual involved with performance improvement will follow administrative policy regarding the disclosure of confidential clinical and management information.

## XIII. Appendices

**Appendix A**
**John H. Stroger, Jr. Hospital**
***e-MERS Event Report Workflow***



**Appendix B**
**John H. Stroger, Jr. Hospital**
***Event Form for Root Cause Analysis Consideration***

**JOHN H. STROGER, JR. HOSPITAL OF COOK COUNTY**

**Toni Preckwinkle** • President
Cook County Board of Commissioners

**David Carvalho** • Chairman
Cook County Health & Hospitals System Board

**Jorge Ramirez** • Vice Chairman
Cook County Health & Hospitals System Board

**Ram Raju MD, MBA, FACS, FACHE** • CEO
Cook County Health & Hospitals System

**John Jay Shannon, M.D.** • Interim COO
Inpatient Services
Cook County Health & Hospitals System

COOK COUNTY HEALTH & HOSPITALS SYSTEM
CCHHS

**Health & Hospitals System Board Members**
Commissioner Jerry Butler
Edward L. Michael
Rev. Calvin S. Morris, PhD
Luis Muñoz, MD
Heather E. O'Donnell
Carmen Velasquez
Dorene P. Wiese, EdD

**MEMORANDUM**

**Date:** May 9, 2014

**To:** Department Oversight Committee

**From:** Krishna Das, MD, Chief Quality Officer

**RE:** Oversight Case Review **OCC-__-14**

On behalf of Cook County Health and Hospital System and the Quality Improvement and Medical Oversight Committees of your facility I am requesting your review of the care of this patient:

**Initials:** **MR#:** **Date(s) of Event:**

**Summary of Issues to be addressed:**

**Please address:** -

We would appreciate your response within the next 30 days or following your next Oversight Committee meeting. Please address any issues in care provided by your department, any description of sentinel events or latent errors ('near misses') and corrective actions that will be undertaken by your Department.

Please send the response to me in writing: Department of Quality, Room 421, Administration Building, 1900 W. Polk Street, Chicago, IL 60612 or by FAX to 312-864-9722. See language below in italics and copy and paste into all correspondence. **Please do not email any responses.**

Cc: Claudia Fegan, MD, Executive Medical Director

*All information provided in these appended materials is compiled at the direction of the Department of Quality and Patient Safety and is privileged and confidential to be used solely in the course of internal quality control and for the purpose of reducing morbidity and mortality and improving the quality of patient care.*

1901 West Harrison Street • Chicago, Illinois 60612 • (312) 864-6000 • TDD (312) 864-0100

• Ambulatory & Community Health Network • Cermak Health Services • Cook County Department of Public Health •
• John H. Stroger, Jr. Hospital • Oak Forest Health Center • Provident Hospital • Ruth M. Rothstein CORE Center •
We Bring HealthCARE to Your Community

**Appendix C**
**John H. Stroger, Jr. Hospital**
**Root Cause Analysis Process: Ground Rules and Guidelines**

***A Root Cause Analysis (RCA) is a systematic investigation technique that uses information gathered during an intense assessment of an undesirable event to determine the underlying reasons for the deficiencies or failures. The goal of the RCA is to identify the basic deficiencies or failures in a process that, if eliminated or corrected, would prevent a similar event from recurring.***

---

- RCAs are designed to answer 3 questions:
    1. What happened?
    2. Why did it happen?
    3. What can be done to prevent it from happening again?

- RCAs focus on processes, not people.

- The RCA process is:
    1. Non-punitive (no blaming) and
    2. Considers special causes (clinical processes) to common causes (organizational processes).

- During the process, we keep asking 'Why?' to determine where redesign might reduce risk.

- The focus is on changes that could be made in processes and systems – either through redesign or development of new systems or processes – to reduce the risk of such events occurring in the future.

- The RCA process recognizes:
    1. Human Factors most directly associated with the sentinel event and
    2. Risk points (points in a process that are susceptible to failure or breakdowns).

Reference: Mooney, B. 2000. Sentinel Events & Root Cause Analysis. American Health Consultants®

**Appendix D**
**John H. Stroger, Jr. Hospital**
***RCA Meeting Form***

Medical Record # _____ Date of Event: _____ Date of RCA: _____

| Sequence of Event | Corrective Actions Taken (at or near the time of the event) | "Parking Lot" (e.g. causes, solutions) |
|---|---|---|
| | | |
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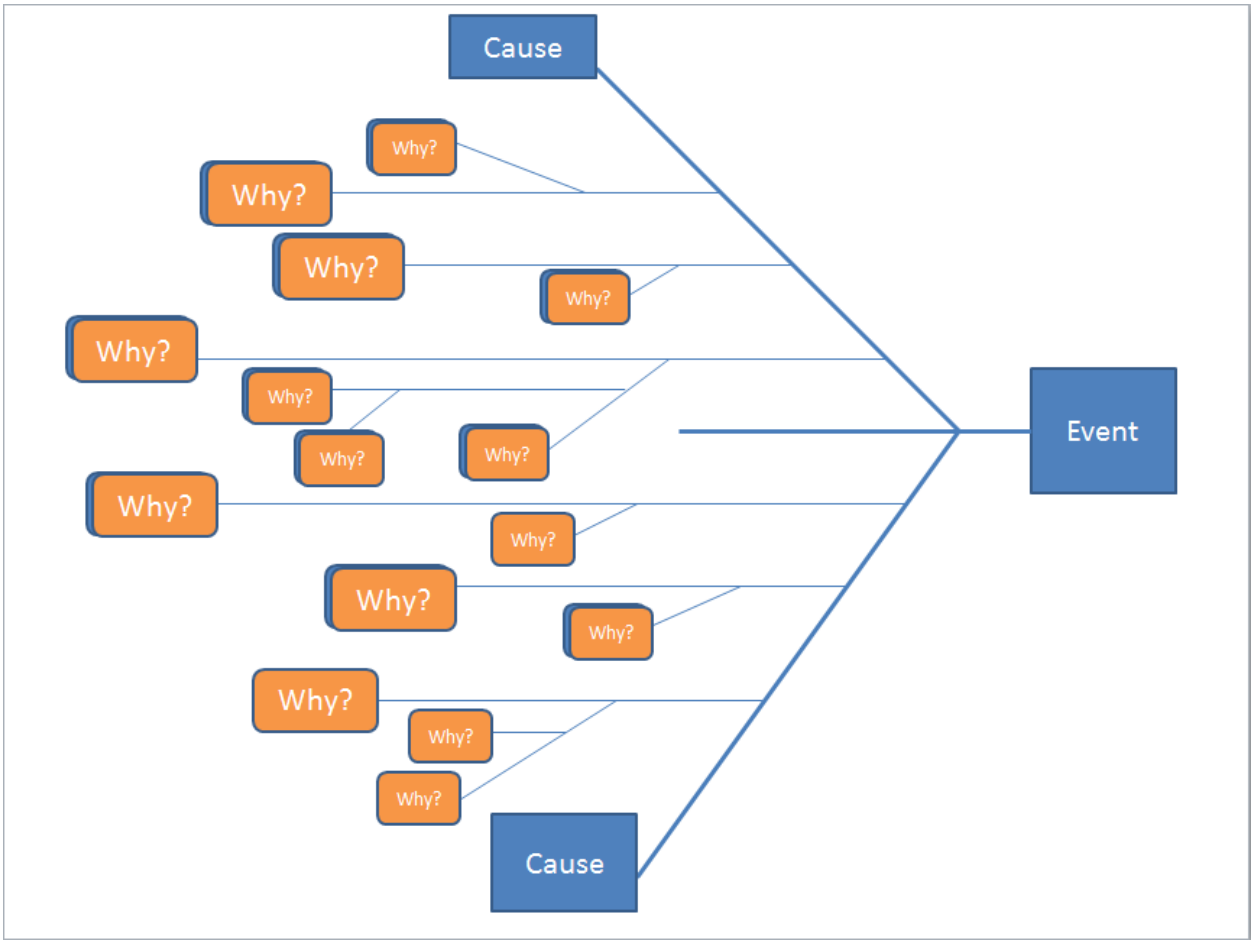
Reference: Mooney, B. 2000. Sentinel Events & Root Cause Analysis. American Health Consultants®

**Appendix E**
**John H. Stroger, Jr. Hospital**
***RCA Contributory Factor Tree***




References: Doggett, A. 2005. Root Cause Analysis: A Framework for Tool Selection. QMJ Vol. 12, No. 4.
Mooney, B. 2000. Sentinel Events & Root Cause Analysis. American Health Consultants®

# ROOT CAUSE ANALYSIS AND ACTION PLAN FRAMEWORK TEMPLATE

**CASE IDENTIFIER:**

**DATE OF RCA:**

**PARTICIPATION:**

---

The Joint Commission Root Cause Analysis and Action Plan tool has 24 analysis questions. The following framework is intended to provide a template for answering the analysis questions and aid organizing the steps in a root cause analysis. All possibilities and questions should be fully considered in seeking "root cause(s)" and opportunities for risk reduction. Not all questions will apply in every case and there may be findings that emerge during the course of the analysis. Be sure however to enter a response in the "Root Cause Analysis Findings" field for each question #. For each finding continue to ask "Why?" and drill down further to uncover why parts of the process occurred or didn't occur when they should have. Significant findings that are not identified as root causes themselves have "roots".

As an aid to avoid "loose ends," the two columns on the right are provided to be checked off for later reference:

- "Root cause" should be answered "Yes" or "No" for each finding. A root cause is typically a finding related to a process or system that has a potential for redesign to reduce risk. If a particular finding is relevant to the event is not a root cause, be sure that it is addressed later in the analysis with a "Why?" question such as "Why did it contribute to the likelihood of the event" or "Why did it contribute to the severity of the event?" Each finding that is identified as a root cause should be considered for an action and addressed in the action plan.
- "Plan of action" should be answered "Yes" for any finding that can reasonably be considered for a risk reduction strategy. Each item checked in this column should be addressed later in the action plan.

***All information provided in these appended materials is compiled at the direction of the Department of Quality and Patient Safety and is privileged and confidential to be used solely in the course of internal quality control and for the purpose of reducing morbidity and mortality and improving the quality of patient care.***

**When did the event occur?**

| Date: | Day of the week: | Time: |
|---|---|---|

**Detailed Event Description Including Timeline:**

**Diagnosis:**

**Medications:**

**Autopsy Results:**

**Past Medical/Psychiatric History:**

| # | Analysis Question | Prompts | Root Cause Analysis Findings | Root cause *(yes/no)* | Plan of Action *("Yes" for any finding that can reasonably be considered for a risk reduction strategy)* |
|---|---|---|---|---|---|
| 1 | What was the intended process flow? | List the relevant process steps as defined by the policy, procedure, protocol, or guidelines in effect at the time of the event. You may need to include multiple processes.<br>***Note***: The process steps *as they occurred in the event* will be entered in the next question.<br>Examples of defined process steps may include, but are not limited to:<br>• Site verification protocol<br>• Instrument, sponge, sharps count procedures<br>• Patient identification protocol<br>• Assessment (pain, suicide risk, physical, and psychological) procedures | | | |

| # | Analysis Question | Prompts | Root Cause Analysis Findings | Root cause *(yes/no)* | Plan of Action *("Yes" for any finding that can reasonably be considered for a risk reduction strategy)* |
|---|---|---|---|---|---|
| | | • Fall risk/fall prevention guidelines | | | |
| 2 | Were there any steps in the process that did not occur as intended? | Explain in detail any deviation from the intended processes listed in Analysis Item #1 above. | | | |
| 3 | What human factors were relevant to the outcome? | Discuss staff-related human performance factors that contributed to the event.<br>Examples may include, but are not limited to:<br>• Boredom<br>• Failure to follow established policies/procedures<br>• Fatigue<br>• Inability to focus on task<br>• Unintentional blindness/ confirmation bias<br>• Personal problems<br>• Lack of complex critical thinking skills<br>• Rushing to complete task<br>• Substance abuse<br>• Trust | | | |
| 4 | How did the equipment performance affect the outcome? | Consider all medical equipment and devices used in the course of patient care, including AED devices, crash carts, suction, oxygen, instruments, monitors, infusion equipment, etc. In your discussion, provide information on the following, as applicable:<br>• Descriptions of biomedical checks<br>• Availability and condition of equipment<br>• Descriptions of equipment with multiple or removable pieces<br>• Location of equipment and its accessibility to staff and patients<br>• Staff knowledge of or education on | | | |

| # | Analysis Question | Prompts | Root Cause Analysis Findings | Root cause *(yes/no)* | Plan of Action *("Yes" for any finding that can reasonably be considered for a risk reduction strategy)* |
|---|---|---|---|---|---|
| | | equipment, including applicable competencies<br>• Correct calibration, setting, operation of alarms, displays, and controls | | | |
| 5 | What controllable environmental factors directly affected this outcome? | What environmental factors within the organization's control affected the outcome?<br>Examples may include, but are not limited to:<br>• Overhead paging that cannot be heard<br>• Safety or security risks<br>• Risks involving activities of visitors<br>• Lighting or space issues<br>The response to this question may be addressed more globally in Question #17.This response should be specific to this event. | | | |
| 6 | What uncontrollable external factors influenced this outcome? | Identify any factors the organization cannot change that contributed to a breakdown in the internal process, for example natural disasters. | | | |
| 7 | Were there any other factors that directly influenced this outcome? | List any other factors not yet discussed. | | | |
| 8 | What are the other areas in the organization where this could happen? | List all other areas in which the potential exists for similar circumstances. For example:<br>• Inpatient surgery/outpatient surgery<br>• Inpatient psychiatric care/outpatient psychiatric care<br>Identification of other areas within the organization that have the potential to impact patient safety in a similar manner. This information will help drive the scope of your action plan. | | | |
| 9 | Was the staff properly qualified and currently competent for their responsibilities at the time of the event? | Include information on the following for all staff and providers involved in the event. Comment on the processes in place to ensure staff is competent and qualified. Examples may include but are not limited to:<br>• Orientation/training<br>• Competency assessment (What competencies do the staff have and how do you evaluate them?)<br>• Provider and/or staff scope of practice concerns<br>• Whether the provider was credentialed and | | | |

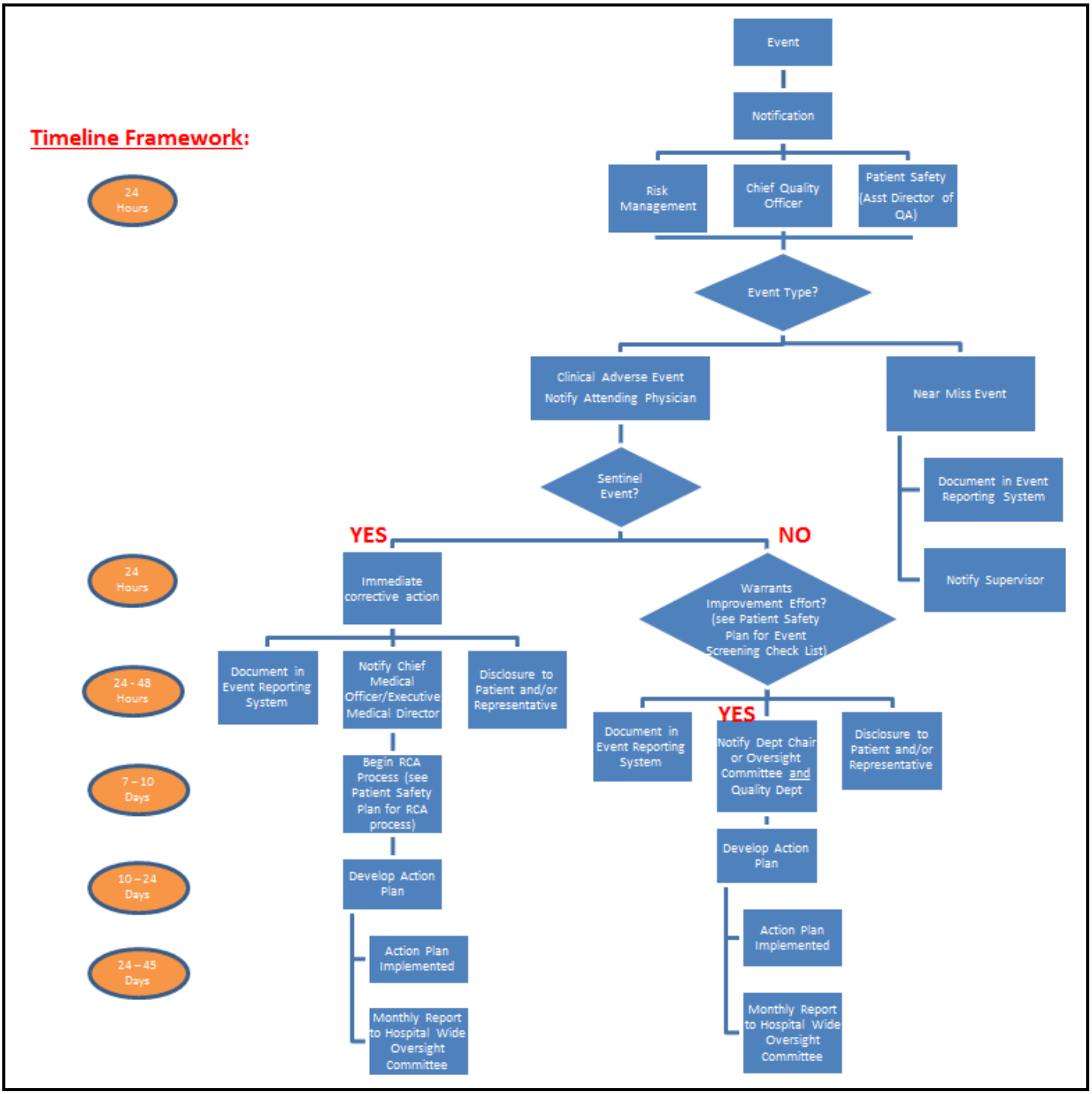
| # | Analysis Question | Prompts | Root Cause Analysis Findings | Root cause *(yes/no)* | Plan of Action *("Yes" for any finding that can reasonably be considered for a risk reduction strategy)* |
|---|---|---|---|---|---|
| | | privileged for the care and services he or she rendered<br>• The credentialing and privileging policy and procedures<br>• Provider and/or staff performance issues | | | |
| 10 | How did actual staffing compare with ideal levels? | Include ideal staffing ratios and actual staffing ratios along with unit census at the time of the event.<br>Note any unusual circumstance that occurred at this time. What process is used to determine the care area's staffing ratio, experience level and skill mix? | | | |
| 11 | What is the plan for dealing with staffing contingencies? | Include information on what the organization does during a staffing crisis, such as call-ins, bad weather or increased patient acuity.<br>Describe the organization's use of alternative staffing. Examples may include, but are not limited to:<br>• Agency nurses<br>• Cross training<br>• Float pool<br>• Mandatory overtime<br>• PRN pool | | | |
| 12 | Were such contingencies a factor in this event? | If alternative staff were used, describe their orientation to the area, verification of competency and environmental familiarity. | | | |
| 13 | Did staff performance during the event meet expectations? | Describe whether staff performed as expected within or outside of the processes. To what extent was leadership aware of any performance deviations at the time? What proactive surveillance processes are in place for leadership to identify deviations from expected processes? Include omissions in critical thinking and/or performance variance(s) from defined policy, procedure, protocol and guidelines in effect at the time. | | | |
| 14 | To what degree was all the necessary information available when needed? Accurate? Complete? Unambiguous? | Discuss whether patient assessments were completed, shared and accessed by members of the treatment team, to include providers, according to the organizational processes.<br>Identify the information systems used during patient care.<br>Discuss to what extent the available patient information (e.g. radiology studies, lab results or medical record) was clear and sufficient to provide | | | |

| # | Analysis Question | Prompts | Root Cause Analysis Findings | Root cause *(yes/no)* | Plan of Action *("Yes" for any finding that can reasonably be considered for a risk reduction strategy)* |
|---|---|---|---|---|---|
| | | an adequate summary of the patient's condition, treatment and response to treatment.<br>Describe staff utilization and adequacy of policy, procedure, protocol and guidelines specific to the patient care provided. | | | |
| 15 | To what degree was the communication among participants adequate for this situation? | Analysis of factors related to communication should include evaluation of verbal, written, electronic communication or the lack thereof. Consider the following in your response, as appropriate:<br>• The timing of communication of key information<br>• Misunderstandings related to language/cultural barriers, abbreviations, terminology, etc.<br>• Proper completion of internal and external hand-off communication<br>• Involvement of patient, family and/or significant other | | | |
| 16 | Was this the appropriate physical environment for the processes being carried out for this situation? | Consider processes that proactively manage the patient care environment. This response may correlate to the response in question 6 on a more global scale.<br>What evaluation tool or method is in place to evaluate process needs and mitigate physical and patient care environmental risks?<br>How are these process needs addressed organization-wide?<br>Examples may include, but are not limited to:<br>• alarm audibility testing<br>• evaluation of egress points<br>• patient acuity level and setting of care managed across the continuum,<br>• preparation of medication outside of pharmacy | | | |
| 17 | What systems are in place to identify environmental risks? | Identify environmental risk assessments.<br>• Does the current environment meet codes, specifications, regulations?<br>• Does staff know how to report environmental risks?<br>• Was there an environmental risk involved in the event that was not previously identified? | | | |

| # | Analysis Question | Prompts | Root Cause Analysis Findings | Root cause *(yes/no)* | Plan of Action *("Yes" for any finding that can reasonably be considered for a risk reduction strategy)* |
|---|---|---|---|---|---|
| 18 | What emergency and failure- mode responses have been planned and tested? | Describe variances in expected process due to an actual emergency or failure mode response in connection to the event.<br>Related to this event, what safety evaluations and drills have been conducted and at what frequency (e.g. mock code blue, rapid response, behavioral emergencies, patient abduction or patient elopement)?<br>Emergency responses may include, but are not limited to:<br>• Fire<br>• External disaster<br>• Mass casualty<br>• Medical emergency<br>Failure mode responses may include, but are not limited to:<br>• Computer down time<br>• Diversion planning<br>• Facility construction<br>• Power loss<br>• Utility issues | | | |
| 19 | How does the organization's culture support risk reduction? | How does the overall culture encourage change, suggestions and warnings from staff regarding risky situations or problematic areas?<br>• How does leadership demonstrate the organization's culture and safety values?<br>• How does the organization measure culture and safety?<br>• How does leadership establish methods to identify areas of risk or access employee suggestions for change?<br>• How are changes implemented? | | | |
| 20 | What are the barriers to communication of potential risk factors? | Describe specific barriers to effective communication among caregivers that have been identified by the organization. For example, residual intimidation or reluctance to report co-worker activity.<br>Identify the measures being taken to break down barriers (e.g. use of SBAR). If there are no barriers to communication discuss how this is known. | | | |
| 21 | How is the prevention of | Describe the organization's adverse outcome | | | |

| # | Analysis Question | Prompts | Root Cause Analysis Findings | Root cause *(yes/no)* | Plan of Action *("Yes" for any finding that can reasonably be considered for a risk reduction strategy)* |
|---|---|---|---|---|---|
| | adverse outcomes communicated as a high priority? | procedures and how leadership plays a role within those procedures. | | | |
| 22 | How can orientation and in-service training be revised to reduce the risk of such events in the future? | Describe how orientation and ongoing education needs of the staff are evaluated and discuss its relevance to event. (e.g. competencies, critical thinking skills, use of simulation labs, evidence based practice, etc.) | | | |
| 23 | Was available technology used as intended? | Examples may include, but are not limited to:<br>• CT scanning equipment<br>• Electronic charting<br>• Medication delivery system<br>• Tele-radiology services | | | |
| 24 | How might technology be introduced or redesigned to reduce risk in the future? | Describe any future plans for implementation or redesign. Describe the ideal technology system that can help mitigate potential adverse events in the future. | | | |

| Action Plan | Organization Plan of Action<br>Risk Reduction Strategies | Position/Title<br>Responsible Party | Method: Policy, Education, Audit, Observation & Implementation |
|---|---|---|---|
| For each of the findings identified in the analysis as needing an action, indicate the planned action expected, implementation date and associated measure of effectiveness. OR. … | Action Item #1: | | |
| If after consideration of such a finding, a decision is made not to implement an associated risk reduction strategy, indicate the rationale for not taking action at this time. | Action Item #2: | | |
| Check to be sure that the selected measure will provide data that will permit assessment of the effectiveness of the action. | Action Item #3: | | |
| Consider whether pilot testing of a planned improvement should be conducted. | Action Item #4: | | |
| Improvements to reduce risk should ultimately be implemented in all areas where applicable, not just where the event occurred. Identify where the improvements will be implemented. | Action Item #5: | | |
| | Action Item #6: | | |
| | Action Item #7: | | |
| | Action Item #8: | | |

Reference: The Joint Commission, 2013. The RCA Framework.

**Appendix G**
**John H. Stroger, Jr. Hospital**
**Event Process and Timeline Framework**